TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

SCOTT & WHITE HEALTH PLAN

Carrier's Austin Representative

Box Number 54

MFDR Date Received

November 5, 2012

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-13-0612-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In response to your letter dated 9/28/12, please see attached the corrected DWC-026 Request for Reimbursement of Payment Made by Health Care Insurer, with additional information regarding the pharmacy charges at the bottom of page 2."

Amount in Dispute: $16,679.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...Texas Mutual has not denied or reduced these bills. There are no EOBs. In fact, the DWC Copies are the first time Texas Mutual received them. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
April 23, 2011 through April 25, 2011	Facility and Professional Services	$16,679.49	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §409.0091 sets out the reimbursement procedures for health care insurers.
2. Texas Labor Code §402.084 sets out the procedures for Record Check; Release of Information.

Issues

1. Did the health care insurer meet the applicable requirements of Texas Labor Code §409.0091?

Findings

Texas Labor Code §409.0091 was added by Acts 2007, 80th Leg., R.S., Ch. 1007 (H.B. 724), Sec. 8, and is effective for dates of injury on or after September 1, 2007, with few exceptions. Texas Labor Code §409.0091(c) states that health care paid by a health care insurer may be reimbursable as a medical benefit. The subclaimant is seeking to recover $16,679.49 from Texas Mutual Insurance Company - a Texas workers' compensation insurance carrier – hereto after referred to as the carrier. The provisions of Texas Labor Code §409.0091 apply to this request for reimbursement and are hereby considered.

1. Texas Labor Code §409.0091 outlines the process by which a health care insurer as defined by Texas Labor Code §402.084(c-1) may be reimbursed by a workers' compensation insurance carrier. A data match pursuant to Texas Labor Code §402.084(c-3) is therefore required by Texas Labor Code §409.0091.

   Review of the documentation provided by the requestor finds the following.

   - The requestor did not provide a position summary with the DWC060 request.
   - Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that a data match occurred prior to the request for reimbursement from the insurance carrier. No documentation was submitted by the requestor and no mention of a data match was made by the requestor in the DWCWC060 request. Due to the insufficient documentation, the Division is unable to verify that a data match occurred. The Division finds that the requestor is therefore not eligible to file for reimbursement from the workers' compensation insurance carrier under Texas Labor Code §409.0091.

   Texas Labor Code §409.0091(n) states, "Except as provided by Subsection (s), a health care insurer must file a request for reimbursement with the workers' compensation insurance carrier not later than six months after the date on which the health care insurer received information under Section 402.084(c-3) and not later than 18 months after the health care insurer paid for the health care service."

   - Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that a data match occurred. The Division is therefore unable to establish that the timeframes outlined above were met by the requestor.

   The Division concludes that the requestor submitted insufficient documentation to reasonable support that it met the conditions of §409.0091.

Conclusion

The outcome of this medical fee dispute relied upon the available evidence presented by the requestor and the respondent. Even though not all the evidence was discussed, it was considered. For the reasons stated above, the Division finds that the requestor failed to establish that additional reimbursement is due. As a result, the amount ordered is zero.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 26, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.